

FILED FEB 14 1952

STANDARD CERTIFICATE OF DEATH

State File No. 2655
348
Registrar's No. 0848

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 20 2614 a No. 22 Street	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) JULIA		b. (Middle) CARROLL	
c. (Last)		5. DATE (Month) (Day) (Year) JAN. 26, 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never Married	8. DATE OF BIRTH April 13 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 72
11. BIRTHPLACE (State or foreign country) Peoria Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Patrich Carroll		13b. MOTHER'S MAIDEN NAME Julia Shea	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Tom O'Day	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Sympho Epithelioma of Tongue</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. INFORMANT'S ADDRESS Tom O'Day 2623 N Spring Ave.	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>145X</i>	
22. I hereby certify that I attended the deceased from <i>11-8-51</i> , 19___, to <i>1-26-52</i> , 19___, that I last saw the deceased alive on <i>1-26-52</i> , 19___, and that death occurred at <i>1:25P m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>H. Knotts, M.D.</i>		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 1-28-52		23d. LOCATION (City, town, or county) (State) St. Louis Mo.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 29 1952	24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
DATE REC'D BY LOCAL REG. JAN 28 1952		REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>mfb</i>		ADDRESS Jos. W Clark 1125 Hodiament Ave.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John J. Haines

Licensed Embalmer No. 4498

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.